

## **EXHIBIT 6**

**W. R. Grace  
Asbestos Personal Injury  
Questionnaire**

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IN THE UNITED STATES BANKRUPTCY COURT  
FOR THE DISTRICT OF DELAWARE

In re: ) Chapter 11  
W. R. GRACE & CO., et al. )  
Debtors. ) Case No. 01-01139 (JKF)  
 ) Jointly Administered  
 )  
 )

**W. R. Grace  
Asbestos Personal Injury  
Questionnaire**

YOU HAVE RECEIVED THIS QUESTIONNAIRE BECAUSE GRACE BELIEVES THAT YOU HAD SUED ONE OR MORE OF THE DEBTORS LISTED IN APPENDIX A ATTACHED TO THIS QUESTIONNAIRE BEFORE GRACE FILED FOR BANKRUPTCY ON APRIL 2, 2001 FOR AN ASBESTOS-RELATED PERSONAL INJURY OR WRONGFUL DEATH CLAIM, AND THAT CLAIM WAS NOT FULLY RESOLVED.

IF YOU HAVE SUCH A CLAIM, YOU MUST COMPLETE AND SUBMIT THIS QUESTIONNAIRE BY JANUARY 12, 2006 TO RUST CONSULTING, INC., THE CLAIMS PROCESSING AGENT, AT ONE OF THE FOLLOWING ADDRESSES:

IF SENT BY U.S. MAIL

IF SENT BY FEDERAL EXPRESS, UNITED PARCEL SERVICE, OR A SIMILAR HAND DELIVERY SERVICE

RUST CONSULTING, INC.  
CLAIMS PROCESSING AGENT  
RE: W.R. GRACE & CO. BANKRUPTCY  
P.O. BOX 1620  
FARIBAULT, MN 55021

RUST CONSULTING, INC.  
CLAIMS PROCESSING AGENT  
RE: W.R. GRACE & CO. BANKRUPTCY  
201 S. LYNDALE AVE.  
FARIBAULT, MN 55021

A QUESTIONNAIRE (AND ANY AMENDMENTS OR ADDITIONAL DOCUMENTS IN SUPPORT OF THE QUESTIONNAIRE) WILL NOT BE CONSIDERED UNLESS RECEIVED BY RUST CONSULTING, INC. BY JANUARY 12, 2006.

THIS QUESTIONNAIRE IS AN OFFICIAL DOCUMENT APPROVED BY THE COURT IN CONNECTION WITH ESTIMATING GRACE'S ASBESTOS-RELATED PERSONAL INJURY AND WRONGFUL DEATH CLAIMS AS A WHOLE. THE QUESTIONNAIRE IS BEING USED BY W. R. GRACE AS A MEANS TO SEEK INFORMATION ABOUT YOUR ASBESTOS CLAIM. BY TIMELY RETURNING THE QUESTIONNAIRE AS COMPLETELY AND ACCURATELY AS POSSIBLE, GRACE, THE OFFICIAL COMMITTEES, AND THE FUTURE CLAIMANTS REPRESENTATIVE WILL SEEK TO PRIORITIZE THE PROCESSING OF YOUR CLAIM UNDER ANY TRUST DISTRIBUTION PROCEDURES APPROVED AS PART OF A PLAN OF REORGANIZATION.

THE COURT HAS ORDERED THAT, AS PART OF THE DISCOVERY PROCESS, ALL HOLDERS OF PRE-PETITION ASBESTOS PERSONAL INJURY CLAIMS MUST COMPLETE AND RETURN THIS QUESTIONNAIRE. THUS, FAILURE TO TIMELY RETURN THE QUESTIONNAIRE AS COMPLETELY AND ACCURATELY AS POSSIBLE MAY RESULT IN SANCTIONS AND/OR OTHER RELIEF AVAILABLE UNDER APPLICABLE FEDERAL RULES.

BECAUSE YOUR CLAIM WILL BE EVALUATED IN ACCORDANCE WITH THE TRUST DISTRIBUTION PROCEDURES APPROVED AS PART OF A PLAN OF REORGANIZATION, COMPLETION OF THIS QUESTIONNAIRE DOES NOT MEAN THAT YOUR CLAIM WILL EITHER BE ALLOWED OR PAID. TO THE EXTENT YOU ATTACH TO THIS QUESTIONNAIRE DOCUMENTS ALSO NEEDED BY THE TRUST TO PROCESS YOUR CLAIM, SUCH DOCUMENTS WILL BE PROVIDED TO THE TRUST AND YOU WILL NOT NEED TO RESUBMIT THEM.

## INSTRUCTIONS

### **A. GENERAL**

1. This Questionnaire refers to any lawsuit that you filed before April 2, 2001 for an "asbestos-related personal injury or wrongful death claim." This term is intended to cover any lawsuit alleging any claim for personal injuries or damages that relates to: (a) exposure to any products or materials containing asbestos that were manufactured, sold, supplied, produced, specified, selected, distributed or in any way marketed by one or more of the Debtors (or any of their respective past or present affiliates, or any of the predecessors of any of the Debtors or any of their respective past or present affiliates), or (b) exposure to vermiculite mined, milled or processed by the Debtors (or any of their respective past or present affiliates, any of the predecessors of any of the Debtors or any of their predecessors' respective past or present affiliates). It includes claims in the nature of or sounding in tort, or under contract, warranty, guarantee, contribution, joint and several liability, subrogation, reimbursement, or indemnity, or any other theory of law or equity, or admiralty for, relating to, or arising out of, resulting from, or attributable to, directly or indirectly, death, bodily injury, sickness, disease, or other personal injuries or other damages caused, or allegedly caused, directly or indirectly, and arising or allegedly arising, directly or indirectly, from acts or omissions of one or more of the Debtors. It includes all such claims, debts, obligations or liabilities for compensatory damages such as loss of consortium, personal or bodily injury (whether physical, emotional or otherwise), wrongful death, survivorship, proximate, consequential, general, special, and punitive damages.
2. Your Questionnaire will be deemed filed only when it has been received by Rust Consulting Inc., the Claims Processing Agent, via U.S. Mail, Federal Express, United Parcel Service or a similar hand delivery service. A Questionnaire that is submitted by facsimile, telecopy or other electronic transmission will **not** be accepted and will **not** be deemed filed.

Do **not** send any Questionnaire to the Debtors, counsel for the Debtors, the Future Claimants Representative, the Official Committee of Unsecured Creditors, the Official Committee of Asbestos Personal Injury Claimants, the Official Committee of Asbestos Property Damage Claimants, the Official Committee of Equity Security Holders, or such Committees' counsel. Questionnaires that are filed with or sent to anyone other than Rust Consulting, Inc. will be deemed not to have been submitted, and such Questionnaires will not be considered.

3. Your completed Questionnaire must (i) be written in English, and (ii) attach relevant supporting materials as instructed further below.
4. All holders of claims described on page i (and as described in further detail in Instruction A (1) above) are required to file this Questionnaire by Jan. 12, 2006. Your Questionnaire will be used in connection with the estimation hearing to be conducted by the Court pursuant to the Estimation Procedures Order (a copy of which is attached as Appendix B).
5. Any subsequent amendment to the Questionnaire will not be considered for any purpose unless received by Jan. 12, 2006.

### **B. PART I -- Identity of Injured Person and Legal Counsel**

Respond to all applicable questions. If you are represented by a lawyer, then in Part I (b), please provide your lawyer's name and the name, telephone number and address of his/her firm. If you are represented by a lawyer, he/she must assist in the completion of this Questionnaire. Also, if you would prefer that the Debtors send any additional materials only to your lawyer, instead of sending such materials to you, then check the box indicating this in Part I (b).

All references to "you" or the like in Parts I through X shall mean the injured person. If the injured person is deceased, then the executor of the person's will (or similar estate representative) must complete this Questionnaire.

### **C. PART II -- Asbestos-Related Condition(s)**

Please indicate all asbestos-related medical conditions for which you have been diagnosed. To complete questions related to injuries, medical diagnoses, and/or conditions, please use the following categories of customarily diagnosed conditions:

- Mesothelioma
- Asbestos-Related Lung Cancer
- Other Cancer (colon, laryngeal, esophageal, pharyngeal, or stomach)
- Clinically Severe Asbestosis
- Asbestosis
- Other Asbestos Disease

If you have been diagnosed with multiple conditions and/or if you received diagnoses and diagnostic tests relating to the same condition by multiple doctors, please complete a separate Part II for each initial diagnosis and any previous or subsequent diagnoses or diagnostic tests that change or conflict with the initial diagnosis. For your convenience, additional copies of Part II are attached as Appendix C to this Questionnaire.

**Supporting Documents for Diagnosis:** This Questionnaire must be accompanied by copies, with access to originals upon request, of any and all documents you, your counsel, or your doctors have or subsequently obtain that support or conflict with your diagnosis.

**X-rays and B-reads:** Please attach all x-ray readings and reports. You may, but are not required to, attach chest x-rays. The court, however, has ruled that Grace may seek access to chest x-rays upon request.

**Pulmonary Function Tests:** Please attach all pulmonary function test results, including the actual raw data and all spirometric tracings, on which the results are based.

**D. PART III – Direct Exposure to Grace Asbestos-Containing Products**

In Part III, please provide the requested information for the job and site at which you were exposed to Grace asbestos-containing products. Indicate the dates of exposure to each Grace asbestos-containing product. If your exposure was a result of your employment, use the list of occupation and industry codes below to indicate your occupation and the industry in which you worked at each site. If you allege exposure to Grace asbestos-containing products at multiple sites, the Court has ordered that you must complete a separate Part III for each site. For your convenience, additional copies of Part III are attached as Appendix D to this Questionnaire.

Attach copies of any and all documents establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the disease.

**Occupation Codes**

01. Air conditioning and heating installer/maintenance	31. Iron worker
02. Asbestos miner	32. Joiner
03. Asbestos plant worker/asbestos manufacturing worker	33. Laborer
04. Asbestos removal/abatement	34. Longshoreman
05. Asbestos sprayer/spray gun mechanic	35. Machinist/machine operator
06. Assembly line/factory/plant worker	36. Millwright/mill worker
07. Auto mechanic/bodywork/brake repairman	37. Mixer/bagger
08. Boilermaker	38. Non-asbestos miner
09. Boiler repairman	39. Non-occupational/residential
10. Boiler worker/cleaner/inspector/engineer/installer	40. Painter
11. Building maintenance/building superintendent	41. Pipefitter
12. Brake manufacturer/installer	42. Plasterer
13. Brick mason/layer/hod carrier	43. Plumber - install/repair
14. Burner operator	44. Power plant operator
15. Carpenter/woodworker/cabinetmaker	45. Professional (e.g., accountant, architect, physician)
16. Chipper	46. Railroad worker/carman/brakeman/machinist/conductor
17. Clerical/office worker	47. Refinery worker
18. Construction - general	48. Remover/installer of gaskets
19. Custodian/janitor in office/residential building	49. Rigger/stevedore/seaman
20. Custodian/janitor in plant/manufacturing facility	50. Rubber/tire worker
21. Electrician/inspector/worker	51. Sandblaster
22. Engineer	52. Sheet metal worker/sheet metal mechanic
23. Firefighter	53. Shipfitter/shipwright/ship builder
24. Fireman	54. Shipyard worker (md. repair, maintenance)
25. Flooring installer/tile installer/tile mechanic	55. Steamfitter
26. Foundry worker	56. Steelworker
27. Furnace worker/repairman/installer	57. Warehouse worker
28. Glass worker	58. Welder/blacksmith
29. Heavy equipment operator (includes truck, forklift, & crane)	59. Other
30. Insulator	

**Industry Codes**

001. Asbestos abatement/removal	109. Petrochemical
002. Aerospace/aviation	110. Railroad
100. Asbestos mining	111. Shipyard-construction/repair
101. Automotive	112. Textile
102. Chemical	113. Tire/rubber
103. Construction trades	114. U.S. Navy
104. Iron/steel	115. Utilities
105. Longshore	116. Grace asbestos manufacture or milling
106. Maritime	117. Non-Grace asbestos manufacture or milling
107. Military (other than U.S. Navy)	118. Other
108. Non-asbestos products manufacturing	

**E. PART IV – Indirect Exposure to Grace Asbestos-Containing Products**

In Part IV, please provide the information requested for any injury alleged to have been caused by exposure to Grace asbestos-containing products through contact/proximity with another injured person. If you allege exposure through contact/proximity with multiple injured persons, please complete a separate Part IV for each injured person. For your convenience, additional copies of Part IV are attached as Appendix E to this Questionnaire.

**F. PART V -- Exposure to Non-Grace Asbestos-Containing Products**

In Part V, please provide the requested information for each party against which you have filed a lawsuit and/or claim alleging exposure to asbestos-containing products other than Grace products. If you filed such lawsuits and/or claims against multiple parties, the Court has ordered that you must complete a separate Part V for each party. If exposure was in connection with your employment, use the list of occupation and industry codes in Part III to indicate your occupation and the industry in which you worked. For your convenience, additional copies of Part V are attached as Appendix F to this Questionnaire.

**G. PART VI -- Employment History**

In Part VI, please provide the information requested for each industrial job you have held, other than jobs already listed in Parts III or V. Use the list of occupation and industry codes in the instructions to Part III to indicate your occupation and the industry in which you worked for each job. Please use the copy of Part VI attached as Appendix G to this Questionnaire if additional space is needed.

**H. PART VII -- Litigation and Claims Regarding Asbestos and/or Silica**

In Part VII, please describe any lawsuits and/or claims that were filed by you or on your behalf regarding asbestos or silica.

**I. PART VIII -- Claims by Dependents or Related Persons**

Part VIII is to be completed only by dependents or related persons (such as spouse or child) of an injured person who sued the Debtors before April 2, 2001 for an asbestos-related personal injury or wrongful death claim against Grace not involving physical injury to him-/herself on account of his/her own exposure. One example of such a claim would be a claim for loss of consortium. If you are asserting such a claim, complete the entire Questionnaire, providing all information and documentation regarding the injured person.

**J. PART IX -- Supporting Documentation**

In Part IX, please mark the boxes next to each type of document that you are submitting with this Questionnaire. As indicated in the instructions to Parts II and III, this Questionnaire must be accompanied by copies, with access to originals upon request, of any and all documents you, your counsel, or your doctors have or subsequently obtain that (a) support or conflict with your diagnosis and/or (b) establish exposure to Grace asbestos-containing products as having a substantial causal role in the development of the medical diagnoses, and/or conditions claimed. Original documents provided to Grace will be returned within a reasonable time after its professionals and experts have reviewed the documents.

Grace will reimburse your reasonable expenses incurred in providing (a) copies of depositions you have given in lawsuits in which Grace was not a party and/or (b) any documents you have previously provided to Grace in prior litigation. Please indicate the documents for which you are seeking reimbursement and attach a receipt for such cost.

**K. PART X -- Attestation that Information is True, Accurate and Complete**

By signing Part X, you, the injured person, are attesting and swearing, under penalty of perjury, that, to the best of your knowledge, all of the information in this Questionnaire is true, accurate and complete. If the injured person is deceased, then the executor of the person's will (or similar estate representative) must complete and sign Part X on behalf of the injured person.

The legal representative of the injured person must complete and sign Part X where indicated.

**PART I: IDENTITY OF INJURED PERSON AND LEGAL COUNSEL****a. GENERAL INFORMATION**

1. Name of Claimant: \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

2. Gender:  Male  Female

3. Race (for purposes of evaluating Pulmonary Function Test results): .....  White/Caucasian  
 African American  
 Other

4. Last Four Digits of Social Security Number: \_\_\_\_\_

5. Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

6. Mailing Address: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

7. Daytime Telephone Number: ..... ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**b. LAWYER'S NAME AND FIRM**

1. Name of Lawyer: \_\_\_\_\_

2. Name of Law Firm With Which Lawyer is Affiliated: \_\_\_\_\_

3. Mailing Address of Firm: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

4. Law Firm's Telephone Number or Lawyer's Direct Line: ..... ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Check this box if you would like the Debtors to send subsequent material relating to your claim to your lawyer, in lieu of sending such materials to you.

**c. CAUSE OF DEATH (IF APPLICABLE)**

1. Is the injured person living or deceased? .....  Living  Deceased  
 If deceased, date of death: ..... \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. If the injured person is deceased, then attach a copy of the death certification to this Questionnaire and complete the following:

Primary Cause of Death (as stated in the Death Certificate): \_\_\_\_\_

Contributing Cause of Death (as stated in the Death Certificate): \_\_\_\_\_

**PART II: ASBESTOS-RELATED CONDITION(S)**

Mark the box next to the conditions with which you have been diagnosed and provide all information required in the instructions to this Questionnaire. If you have been diagnosed with multiple conditions and/or if you received diagnoses and diagnostic tests relating to the same condition by multiple doctors, please complete a separate Part II for each initial diagnosis and any previous or subsequent diagnoses or diagnostic tests that change or conflict with the initial diagnosis. For your convenience, additional copies of Part II are attached as Appendix C to this Questionnaire.

**1. Please check the box next to the condition being alleged:**

<input type="checkbox"/> Asbestos-Related Lung Cancer	<input type="checkbox"/> Mesothelioma
<input type="checkbox"/> Asbestosis	<input type="checkbox"/> Other Cancer (cancer not related to lung cancer or mesothelioma)
<input type="checkbox"/> Other Asbestos Disease	<input type="checkbox"/> Clinically Severe Asbestosis

**a. Mesothelioma:** If alleging Mesothelioma, were you diagnosed with malignant mesothelioma based on the following (check all that apply):

- diagnosis from a pathologist certified by the American Board of Pathology
- diagnosis from a second pathologist certified by the American Board of Pathology
- diagnosis and documentation supporting exposure to Grace asbestos-containing products having a substantial causal role in the development of the condition
- other (please specify): \_\_\_\_\_

**PART II: ASBESTOS-RELATED CONDITION(S) (Continued)**

**b. Asbestos-Related Lung Cancer:** If alleging Asbestos-Related Lung Cancer, were you diagnosed with primary lung cancer based on the following (check all that apply):

- findings by a pathologist certified by the American Board of Pathology
- evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a B-reader certified by the National Institute for Occupational Safety and Health
- evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a second B-reader certified by the National Institute for Occupational Safety and Health
- evidence of asbestosis determined by pathology
- evidence of asbestos-related nonmalignant disease based on a chest x-ray reading of at least 1/0 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a B-reader certified by the National Institute for Occupational Safety and Health
- evidence of asbestos-related nonmalignant disease based on a chest x-ray reading of at least 1/0 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a second B-reader certified by the National Institute for Occupational Safety and Health
- diffuse pleural thickening as defined in the International Labour Organization's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the lung cancer
- other (please specify): \_\_\_\_\_

**c. Other Cancer:**

(i) If alleging Other Cancer, please mark the box(es) next to the applicable primary cancer(s) being alleged:

- colon
- pharyngeal
- esophageal
- laryngeal
- stomach cancer
- other, please specify: \_\_\_\_\_

(ii) Were you diagnosed with the above-indicated cancer based on the following (check all that apply):

- findings by a pathologist certified by the American Board of Pathology
- evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a B-reader certified by the National Institute for Occupational Safety and Health
- evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a second B-reader certified by the National Institute for Occupational Safety and Health
- evidence of asbestosis determined by pathology
- a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the cancer
- other (please specify): \_\_\_\_\_

**PART II: ASBESTOS-RELATED CONDITION(S) (Continued)**

d. **Clinically Severe Asbestosis:** If alleging Clinically Severe Asbestosis, was your diagnosis based on the following (check all that apply):

- diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine
- a chest x-ray reading of at least 2/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a B-reader certified by the National Institute for Occupational Safety and Health
- a chest x-ray reading of at least 2/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b) by a second B-reader certified by the National Institute for Occupational Safety and Health
- asbestosis determined by pathology
- a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing: Selection of Reference Values and Interpretive Strategies*, demonstrating total lung capacity less than 65% predicted
- a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing: Selection of Reference Values and Interpretive Strategies*, demonstrating forced vital capacity less than 65% predicted and a FEV1/FVC ratio greater than or equal to 65% predicted
- a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis
- other (please specify): \_\_\_\_\_

e. **Asbestosis:** If alleging Asbestosis, was your diagnosis based on the following (check all that apply):

- diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine
- a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a second B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- asbestosis determined by pathology
- a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing: Selection of Reference Values and Interpretive Strategies*, demonstrating a FEV1/FVC ratio greater than or equal to 65% predicted with either (a) total lung capacity less than 80% predicted or (b) forced vital capacity less than 80% predicted
- a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis
- other (please specify): \_\_\_\_\_

**PART II: ASBESTOS-RELATED CONDITION(S) (Continued)**

f. **Other Asbestos Disease:** If alleging any asbestos-related injuries, medical diagnoses, and/or conditions other than those above, was your diagnosis based on the following (check all that apply):

- diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine
- diagnosis determined by pathology
- a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a second B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- a chest x-ray reading other than those described above
- a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing: Selection of Reference Values and Interpretive Strategies*, demonstrating a FEVI/FVC ratio greater than or equal to 65% predicted with either (a) total lung capacity less than 80% predicted or (b) forced vital capacity less than 80% predicted
- a pulmonary function test other than that discussed above
- a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the condition
- a CT Scan or similar testing
- a diagnosis other than those above
- other (please specify): \_\_\_\_\_

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**PART II: ASBESTOS-RELATED CONDITION(S) (Continued)****2. Information Regarding Diagnosis**

Date of Diagnosis: ..... / \_\_\_\_ / \_\_\_\_

Diagnosing Doctor's Name: \_\_\_\_\_

Diagnosing Doctor's Specialty: \_\_\_\_\_

Diagnosing Doctor's Mailing Address: \_\_\_\_\_  
Address

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Diagnosing Doctor's Daytime Telephone Number: ..... ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

**With respect to your relationship to the diagnosing doctor, check all applicable boxes:**Was the diagnosing doctor your personal physician? .....  Yes  NoWas the diagnosing doctor paid for the diagnostic services that he/she performed? .....  Yes  No*If yes, please indicate who paid for the services performed:* \_\_\_\_\_Did you retain counsel in order to receive any of the services performed by the diagnosing doctor? .....  Yes  NoWas the diagnosing doctor referred to you by counsel? .....  Yes  NoAre you aware of any relationship between the diagnosing doctor and your legal counsel? .....  Yes  No*If yes, please explain:* \_\_\_\_\_**Was the diagnosing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the diagnosis?** .....  Yes  No**Was the diagnosing doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis?** .....  Yes  No**Was the diagnosing doctor provided with your complete occupational, medical and smoking history prior to diagnosis?** .....  Yes  No**Did the diagnosing doctor perform a physical examination?** .....  Yes  No**Do you currently use tobacco products?** .....  Yes  No**Have you ever used tobacco products?** .....  Yes  No**If answer to either question is yes, please indicate whether you have regularly used any of the following tobacco products and the dates and frequency with which such products were used:** Cigarettes      Packs Per Day (half pack = .5) \_\_\_\_\_      Start Year \_\_\_\_\_ End Year \_\_\_\_\_ Cigars      Cigars Per Day \_\_\_\_\_      Start Year \_\_\_\_\_ End Year \_\_\_\_\_ If Other Tobacco Products, please specify (e.g., chewing tobacco): \_\_\_\_\_  
Amount Per Day \_\_\_\_\_      Start Year \_\_\_\_\_ End Year \_\_\_\_\_**Have you ever been diagnosed with chronic obstructive pulmonary disease ("COPD")?** .....  Yes  No*If yes, please attach all documents regarding such diagnosis and explain the nature of the diagnosis:* \_\_\_\_\_**3. Information Regarding Chest X-Ray****Please check the box next to the applicable location where your chest x-ray was taken (check one):** Mobile laboratory  Job site  Union Hall  Doctor office  Hospital  Other: \_\_\_\_\_**Address where chest x-ray taken:** \_\_\_\_\_  
Address

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

**PART II: ASBESTOS-RELATED CONDITION(S) (Continued)****4. Information Regarding Chest X-Ray Reading**

Date of Reading: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ - \_\_\_\_

ILO score: \_\_\_\_\_

Name of Reader: \_\_\_\_\_

Reader's Daytime Telephone Number: .....(\_\_\_\_\_) \_\_\_\_ - \_\_\_\_

Reader's Mailing Address: \_\_\_\_\_

Address

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

**With respect to your relationship to the reader, check all applicable boxes:**Was the reader paid for the services that he/she performed..... Yes  No*If yes, please indicate who paid for the services performed:* \_\_\_\_\_Did you retain counsel in order to receive any of the services performed by the reader? ..... Yes  NoWas the reader referred to you by counsel? ..... Yes  NoAre you aware of any relationship between the reader and your legal counsel? ..... Yes  No*If yes, please explain:* \_\_\_\_\_**Was the reader certified by the National Institute for Occupational Safety and Health at the time of the reading?**..... Yes  No*If the reader is not a certified B-reader, please describe the reader's occupation, specialty, and the method through which the reading was made:* \_\_\_\_\_**5. Information Regarding Pulmonary Function Test:** .....**Date of Test:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ - \_\_\_\_

List your height in feet and inches when test given: ..... ft \_\_\_\_\_ inches

List your weight in pounds when test given: ..... lbs

Total Lung Capacity (TLC): ..... % of predicted

Forced Vital Capacity (FVC): ..... % of predicted

FEV1/FVC Ratio: ..... % of predicted

Name of Doctor Performing Test (if applicable): \_\_\_\_\_

Doctor's Specialty: \_\_\_\_\_

Name of Clinician Performing Test (if applicable): \_\_\_\_\_

Testing Doctor or Clinician's Mailing Address: \_\_\_\_\_

Address

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Testing Doctor or Clinician's Daytime Telephone Number: .....(\_\_\_\_\_) \_\_\_\_ - \_\_\_\_

Name of Doctor Interpreting Test: \_\_\_\_\_

Doctor's Specialty: \_\_\_\_\_

Interpreting Doctor's Mailing Address: \_\_\_\_\_

Address

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Interpreting Doctor's Daytime Telephone Number: .....(\_\_\_\_\_) \_\_\_\_ - \_\_\_\_

**PART II: ASBESTOS-RELATED CONDITION(S) (Continued)**

**With respect to your relationship to the doctor or clinician who performed the pulmonary function test check all applicable boxes:**

If the test was performed by a doctor, was the doctor your personal physician?.....  Yes  No

Was the testing doctor and/or clinician paid for the services that he/she performed? .....  Yes  No

*If yes, please indicate who paid for the services performed: \_\_\_\_\_*

Did you retain counsel in order to receive any of the services performed by the testing doctor or clinician? ..  Yes  No

Was the testing doctor or clinician referred to you by counsel? .....  Yes  No

Are you aware of any relationship between either the doctor or clinician and your legal counsel? .....  Yes  No

*If yes, please explain: \_\_\_\_\_*

**Was the testing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the pulmonary function test? .....  Yes  No**

**With respect to your relationship to the doctor interpreting the results of the pulmonary function test check all applicable boxes:**

Was the doctor your personal physician? .....  Yes  No

Was the doctor paid for the services that he/she performed? .....  Yes  No

*If yes, please indicate who paid for the services performed: \_\_\_\_\_*

Did you retain counsel in order to receive any of the services performed by the doctor? .....  Yes  No

Was the doctor referred to you by counsel? .....  Yes  No

Are you aware of any relationship between the doctor and your legal counsel? .....  Yes  No

*If yes, please explain: \_\_\_\_\_*

**Was the doctor interpreting the pulmonary function test results certified as a pulmonologist or internist by the American Board of Internal Medicine at the time the test results were reviewed? .....  Yes  No**

**6. Information Regarding Pathology Reports:**

**Date of Pathology Report:** ..... / /

**Findings:** \_\_\_\_\_

**Name of Doctor Issuing Report:** \_\_\_\_\_

**Doctor's Specialty:** \_\_\_\_\_

**Doctor's Mailing Address:** \_\_\_\_\_  
Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

**Doctor's Daytime Telephone Number:** ..... (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**With respect to your relationship to the doctor issuing the pathology report, check all applicable boxes:**

Was the doctor your personal physician? .....  Yes  No

Was the doctor paid for the services that he/she performed? .....  Yes  No

*If yes, please indicate who paid for the services performed: \_\_\_\_\_*

Did you retain counsel in order to receive any of the services performed by the doctor? .....  Yes  No

Was the doctor referred to you by counsel? .....  Yes  No

Are you aware of any relationship between the doctor and your legal counsel? .....  Yes  No

*If yes, please explain: \_\_\_\_\_*

**Was the doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis?**

.....  Yes  No

**PART II: ASBESTOS-RELATED CONDITION(S) (Continued)**

7. With respect to the condition alleged, have you received medical treatment from a doctor for the condition?

.....  Yes  No

*If yes, please complete the following:*

**Name of Treating Doctor:** \_\_\_\_\_

**Treating Doctor's Specialty:** \_\_\_\_\_

**Treating Doctor's Mailing Address:** \_\_\_\_\_  
Address

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

**Treating Doctor's Daytime Telephone number:** ..... ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

**Was the doctor paid for the services that he/she performed?** .....  Yes  No

*If yes, please indicate who paid for the services performed:.* \_\_\_\_\_

**Did you retain counsel in order to receive any of the services performed by the doctor?** .....  Yes  No

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**PART III: DIRECT EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS**

Please complete the chart below for each site at which you allege exposure to Grace asbestos-containing products. If you allege exposure at multiple sites, the Court has ordered that you must complete a separate chart for each site. For your convenience, additional copies of Part III are attached as Appendix D to this Questionnaire.

If exposure was in connection with your employment, use the list of occupation and industry codes in the Instructions to Part III to indicate your occupation and the industry in which you worked.

In the "Nature of Exposure" column, for each job listed, please indicate the letter(s) corresponding to whether you were any of the following during your exposure:

(a) A worker who personally mixed Grace asbestos-containing products	(d) A worker at a site where Grace asbestos-containing products were being installed, mixed, removed or cut by others
(b) A worker who personally removed or cut Grace asbestos-containing products	(e) A worker in a space where Grace asbestos-containing products were being installed, mixed, removed or cut by others
(c) A worker who personally installed Grace asbestos-containing products	
(f) If other, please specify: _____	

**Site of Exposure:**

Site Name: \_\_\_\_\_

Location: \_\_\_\_\_

Site Type:  Residence  Business

Site Owner: \_\_\_\_\_

Employer During Exposure: \_\_\_\_\_

Unions of which you were a member during your employment: \_\_\_\_\_

Job 1 Description:	Product(s)	Basis for Identification of Each Grace Product	Dates and Frequency of Exposure (hours/day, days/year)	Occupation Code <i>If Code 59, specify.</i>	Industry Code <i>If Code 118, specify.</i>	Was exposure due to working in or around areas where product was being installed, mixed, removed, or cut? <i>If Yes, please indicate your regular proximity to such areas</i>	Nature of Exposure
Job 2 Description:							
Job 3 Description:							
Job 4 Description:							
Job 5 Description:							
Job 6 Description:							

**PART IV: INDIRECT EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS**

1. Are you asserting an injury caused by exposure to Grace asbestos-containing products through contact/proximity with another injured person? .....  Yes  No

*If yes, complete questions 2 through 10 of this section for each injured person through which you allege exposure to Grace asbestos-containing products. For your convenience, additional copies of Part IV are attached as Appendix E to this Questionnaire.*

2. Please indicate the following information regarding the other injured person:

Name of Other Injured Person: \_\_\_\_\_ Gender:  Male  Female

Last Four Digits of Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. What is your Relationship to Other Injured Person: .....  Spouse  Child  Other

4. Nature of Other Injured Person's Exposure to Grace Asbestos-Containing Products:

\_\_\_\_\_

5. Dates Other Injured Person was Exposed to Grace Asbestos-Containing Products:

From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

6. Other Injured Person's Basis for Identification of Asbestos-Containing Product as Grace Product:

\_\_\_\_\_

7. Has the Other Injured Person filed a lawsuit related to his/her exposure? .....  Yes  No

*If yes, please provide caption, case number, file date, and court name for the lawsuit:*

Caption: \_\_\_\_\_

Case Number: \_\_\_\_\_ File Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Court Name: \_\_\_\_\_

8. Nature of Your Own Exposure to Grace Asbestos-Containing Product:

\_\_\_\_\_

9. Dates of Your Own Exposure to Grace Asbestos-Containing Product:

From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

10. Your Basis for Identification of Asbestos-Containing Product as Grace Product:

\_\_\_\_\_

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**PART V: EXPOSURE TO NON-GRACE ASBESTOS-CONTAINING PRODUCTS**

Please complete the chart below for each party against which you have filed a lawsuit and/or claim alleging exposure to asbestos-containing products other than Grace products. If you filed such lawsuits and/or claims against multiple parties, the Court has ordered that you must complete a separate chart for each party. For your convenience, additional copies of Part V are attached as Appendix F to this Questionnaire.

If exposure was in connection with your employment, use the list of occupation and industry codes in the Instructions to Part III to indicate your occupation and the industry in which you worked.

In the "Nature of Exposure" column, for each product listed, please indicate the letter(s) corresponding to whether you were any of the following during your exposure:

- (a) A worker who personally mixed Non-Grace asbestos-containing products
- (b) A worker who personally removed or cut Non-Grace asbestos-containing products
- (c) A worker who personally installed Non-Grace asbestos-containing products
- (d) A worker at a site where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
- (e) A worker in a space where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
- (f) If other, please specify.

Party Against which Lawsuit or Claim was Filed:	Product(s)	Dates and Frequency of Exposure (hours/day, days/year)	Occupation Code <i>If Code 59, specify.</i>	Industry Code <i>If Code 118, specify.</i>	Nature of Exposure <i>If Yes, please indicate your regular proximity to such areas</i>
<b>Site of Exposure 1</b>	Job 1 Description: Site Name: _____ Address: _____ City and State: _____ Site Owner: _____				
	Job 2 Description:				
	Job 3 Description:				
<b>Site of Exposure 2</b>	Job 1 Description: Site Name: _____ Address: _____ City and State: _____ Site Owner: _____				
	Job 2 Description:				
	Job 3 Description:				
<b>Site of Exposure 3</b>	Job 1 Description: Site Name: _____ Address: _____ City and State: _____ Site Owner: _____				
	Job 2 Description:				
	Job 3 Description:				

**PART VI: EMPLOYMENT HISTORY**

Other than jobs listed in Part III or V, please complete this Part VI for all of your prior industrial work experience up to and including your current employment. For each job, include your employer, location of employment, and dates of employment. Only include jobs at which you worked for at least one month. Please use the copy of Part VI attached as Appendix G to this Questionnaire if additional space is needed.

**Occupation Code:** \_\_\_\_\_ If Code 59, specify: \_\_\_\_\_

**Industry Code:** \_\_\_\_\_ If Code 118, specify: \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Beginning of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_ **End of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_

**Location:** \_\_\_\_\_

Address

City	State/Province	Zip/Postal Code
------	----------------	-----------------

**Occupation Code:** \_\_\_\_\_ If Code 59, specify: \_\_\_\_\_

**Industry Code:** \_\_\_\_\_ If Code 118, specify: \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Beginning of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_ **End of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_

**Location:** \_\_\_\_\_

Address

City	State/Province	Zip/Postal Code
------	----------------	-----------------

**Occupation Code:** \_\_\_\_\_ If Code 59, specify: \_\_\_\_\_

**Industry Code:** \_\_\_\_\_ If Code 118, specify: \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Beginning of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_ **End of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_

**Location:** \_\_\_\_\_

Address

City	State/Province	Zip/Postal Code
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**Occupation Code:** \_\_\_\_\_ If Code 59, specify: \_\_\_\_\_

**Industry Code:** \_\_\_\_\_ If Code 118, specify: \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Beginning of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_ **End of Employment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_-\_\_\_\_

**Location:** \_\_\_\_\_

Address

City	State/Province	Zip/Postal Code
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**PART VII: LITIGATION AND CLAIMS REGARDING ASBESTOS AND/OR SILICA****a. LITIGATION**

1. Have you ever been a plaintiff in a lawsuit regarding asbestos or silica? .....  Yes  No

*If yes, please complete the rest of this Part VII(a) for each lawsuit. For your convenience, additional copies of Part VII are attached as Appendix G to this Questionnaire*

2. Please provide the caption, case number, file date, and court name for the lawsuit you filed:

**Caption:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_ **File Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Court Name:** \_\_\_\_\_

3. Was Grace a defendant in the lawsuit? .....  Yes  No

4. Was the lawsuit dismissed against any defendant? .....  Yes  No

*If yes, please provide the basis for dismissal of the lawsuit against each defendant:*

\_\_\_\_\_

5. Has a judgment or verdict been entered? .....  Yes  No

*If yes, please indicate verdict amount for each defendant(s):* \_\_\_\_\_

6. Was a settlement agreement reached in this lawsuit? .....  Yes  No

*If yes and the settlement was reached on or after April 2, 2001, please indicate the following:*

a. Settlement amount for each defendant: \_\_\_\_\_

b. Applicable defendants: \_\_\_\_\_

c. Disease or condition alleged: \_\_\_\_\_

d. Disease or condition settled (if different than disease or condition alleged): \_\_\_\_\_

7. Were you deposed in this lawsuit? .....  Yes  No

*If yes and Grace was not a party in the lawsuit, please attach a copy of your deposition to this Questionnaire.*

**b. CLAIMS**

1. Have you ever asserted a claim regarding asbestos and/or silica, including but not limited to a claim against an asbestos trust (other than a formal lawsuit in court)? .....  Yes  No

*If yes, please complete the rest of this Part VII(b). If no, please skip to Part VIII.*

2. Date the claim was submitted: ..... \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. Person or entity against whom the claim was submitted: \_\_\_\_\_

4. Description of claim: \_\_\_\_\_

5. Was claim settled? .....  Yes  No

6. Please indicate settlement amount: ..... \$ \_\_\_\_\_

7. Was the claim dismissed or otherwise disallowed or not honored? .....  Yes  No

*If yes, provide the basis for dismissal of the claim:* \_\_\_\_\_

**PART VIII: CLAIMS BY DEPENDENTS OR RELATED PERSONS**Name of Dependent or Related Person: \_\_\_\_\_ Gender:  Male  Female

Last Four Digits of Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Financially Dependent: .....  Yes  NoRelationship to Injured Party:  Spouse  Child  Other If other, please specify \_\_\_\_\_Mailing Address: \_\_\_\_\_  
Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Daytime Telephone number: ..... (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_

**PART IX: SUPPORTING DOCUMENTATION**

Please use the checklists below to indicate which documents you are submitting with this form.

**Copies:**

<input type="checkbox"/> Medical records and/or report containing a diagnosis	<input type="checkbox"/> X-rays
<input type="checkbox"/> Lung function test results	<input type="checkbox"/> X-ray reports/interpretations
<input type="checkbox"/> Lung function test interpretations	<input type="checkbox"/> CT scans
<input type="checkbox"/> Pathology reports	<input type="checkbox"/> CT scan reports/interpretations
<input type="checkbox"/> Supporting documentation of exposure to Grace asbestos-containing products	<input type="checkbox"/> Depositions from lawsuits indicated in Part VII of this Questionnaire
<input type="checkbox"/> Supporting documentation of other asbestos exposure	<input type="checkbox"/> Death Certification

**Originals:**

<input type="checkbox"/> Medical records and/or report containing a diagnosis	<input type="checkbox"/> Supporting documentation of other asbestos exposure
<input type="checkbox"/> Lung function test results	<input type="checkbox"/> X-rays
<input type="checkbox"/> Lung function test interpretations	<input type="checkbox"/> X-ray reports/interpretations
<input type="checkbox"/> Pathology reports	<input type="checkbox"/> CT scans
<input type="checkbox"/> Supporting documentation of exposure to Grace asbestos-containing products	<input type="checkbox"/> CT scan reports/interpretations
	<input type="checkbox"/> Death Certification

Grace will reimburse your reasonable expenses incurred in providing (a) copies of depositions you have given in lawsuits in which Grace was not a party and/or (b) any documents you have previously provided to Grace in prior litigation. Please indicate the documents for which you are seeking reimbursement and attach a receipt for such costs:

**PART X: ATTESTATION THAT INFORMATION IS TRUE AND ACCURATE**

The information provided in this Questionnaire must be accurate and truthful. This Questionnaire is an official court document that may be used as evidence in any legal proceeding regarding your Claim. The penalty for presenting a fraudulent Questionnaire is a fine of up to \$500,000 or imprisonment for up to five years, or both. 18 U.S.C. §§ 152 & 3571.

**TO BE COMPLETED BY THE INJURED PERSON.**

I swear, under penalty of perjury, that, to the best of my knowledge, all of the foregoing information contained in this Questionnaire is true, accurate and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please Print Name: \_\_\_\_\_

**TO BE COMPLETED BY THE LEGAL REPRESENTATIVE OF THE INJURED PERSON.**

I swear that, to the best of my knowledge, all of the information contained in this Questionnaire is true, accurate and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please Print Name: \_\_\_\_\_